VERMONT STATE HOSPITAL
POLICIES AND PROCEDURES

Title: VSH Positive Behavior Supports Policy	**Effective Date:**
Division: Program **Policy #:**	**First Issued:**
Responsible Department/Unit: **Psychology Service**	**Reviewed/Revised: 9/13/07**
Approved by:	**Signature:** _____ **Date Signed** _____ **Date Signed**

I. Purpose

This policy establishes guidelines for the development, implementation, and evaluation of a spectrum of behavioral applications for patient care; to outline the functions and responsibilities of the Psychology Service with regard to Behavior Supports Services within the hospital; and to inform clinical staff of their roles in relation to Behavior Supports Services.

II. Policy

Patients shall receive timely access to safe and effective interdisciplinary and behavioral interventions that promote acquisition of adaptive, pro-social behaviors and facilitate recovery**.** Vermont State Hospital offers a broad range of assessment and treatment services, based on behavioral science and technology, which are available to all patients. These services seek to improve adaptive capabilities and minimize problems that interfere with the quality of life and adjustment to a community setting. Behavioral treatment services are consistent with a positive behavioral supports philosophy and comply with standards of care as outlined in guidelines of professional provider organizations.

III. Procedure

A. OVERVIEW OF BEHAVIOR SUPPORTS SERVICES

The Psychology Service shall provide a range of Behavior Supports Services that promote acquisition of adaptive, pro-social behaviors and facilitate recovery and

help to minimize the occurrence of behaviors which interfere with recovery and community integration. Specifically, the Psychology Service provides:

1. Behaviorally-informed education and training for staff, including overview of Behavior Support Services in Clinical Employee Orientation;
2. Consultation with treatment teams assisting patients to develop pro-social and adaptive behaviors and to minimize behaviors which interfere with recovery and community re-integration;
3. Assessment of patients exhibiting behavior problems;
4. Psychometric Assessments of patients for whom such test data may aid the Unit Team in determining accurate diagnoses, or designing effective treatment interventions and/or discharge plans.
5. Facilitation of positive interventions to increase motivation in treatment;
6. Assistance in developing interdisciplinary treatment plans to address behavioral issues;
7. Assistance and support in developing and implementing behavioral interventions for patients; and
8. Development and implementation of institutional policies related to behavioral interventions.

Behavioral interventions and interdisciplinary interventions targeting behavioral issues shall occur at both the milieu and individual level. Behavioral interventions shall be based on positive (as oppose to aversive) contingencies and shall not involve limiting a patient's choices or freedom of movement beyond what is otherwise encountered in an inpatient setting.

1. **Milieu Behavior Supports Services**

   Behavioral methods such as instruction, prompting, shaping, modeling, and social reinforcement are inherent in staff-patient interactions in the provision of daily care. Direct care staff members are trained to model and encourage adaptive behavior regardless of whether those behaviors are specifically outlined in the Unit program or in an individualized treatment plan. The Psychology Service shall provide training, ongoing instruction, and consultation to unit staff in support of these efforts.

2. **Individual Behavior Supports Services**

   The Psychology Service shall provide consultation, interdisciplinary recommendations, and behavioral interventions to address individual behavioral issues upon referral from unit teams.

B. REQUESTS FOR CONSULTATION

1. The following situations are some indicators of the need for a behavioral consultation:

a. Frequent/ongoing need for seclusion, restraint, and/or constant visual monitoring to prevent aggressive or self-harm behaviors that have not been resolved through rapid stabilization or intensive treatment efforts.
b. Need for frequent PRN medication administrations to prevent aggressive or self-harm behaviors that have not been resolved through rapid stabilization or intensive treatment efforts.
c. Injuries to self or others resulting from an individual's behaviors that have not been resolved through rapid stabilization or intensive treatment efforts.
d. Presence of behaviors which are interfering with the individual's recovery or community reintegration.
e. Deficits in pro-social or adaptive behaviors which are interfering with the individual's ability to benefit from treatment and make progress on life or treatment goals.
f. Ongoing medication non-adherence.
g. Absence of meaningful engagement in treatment.
h. Problem behaviors related to the presence of dementia.

Consultations shall occur:

a. In the context of routine treatment planning meetings (for non-urgent requests).
b. On an emergency basis for behaviors requiring more immediate intervention to minimize risk of harm to the patient or others.
c. Following notification from the Quality Assurance Department that the patient has met a risk threshold indicating behavioral problems whose intensity or frequency poses a risk to the patient or others or is requiring restrictive interventions (e.g., seclusion, restraint) to prevent harm from occurring.

Referrals to the Psychology Service for a Behavior Supports Service Consultation will be made:

a. By the team leader using a consultation form which specifies the behaviors of concern and the urgency of the request for consultation.
b. By the Quality Assurance Department in response to monitoring of risk thresholds.

C. CONSULTATION AND FEEDBACK

1. Upon receiving a request for consultation, the psychologist assigned to the team making the request will review the patient's medical record and meet with the referring treatment team to discuss the behaviors of concern, identify interventions already tried, identify patient characteristics relevant to

treatment (e.g., motivation, strengths) and determine factors potentially contributing to the problematic behaviors.

2. During the consultation meeting, the team shall update the patient's treatment plan to reflect interventions decided upon during the meeting. Interventions may involve activities from any discipline but will be specifically designed to address behaviors.
3. On the basis of this consultation, and any additional assessments identified as necessary during the consultation, the psychologist will develop a comprehensive list of recommendations. Written feedback on consultations is provided to treatment teams within 48 hours of consultation via the **Behavioral Consultation Feedback Form (Appendix A).** This feedback may be more extensive than that provided in the initial meeting and may include additional recommendations for the team. Written feedback is maintained in the progress notes section of the Patient's Medical Record.
4. Upon receipt of feedback the treatment team shall review the recommendations and make decisions about implementation of any additional recommendations. New interventions resulting from this review will be included as an addendum to the current treatment plan and integrated into the treatment plan at the next treatment plan review. When integrated into the treatment plan, these interventions will be specifically listed as an intervention under one or more relevant problems and the goal statements for those problems.

D. FUNCTIONAL ASSESSMENT

1. In the case of some more difficult and/or long-standing behavioral concerns, a more formal Functional Assessment may be conducted in order to identify those factors contributing to the development and/or maintenance of problem behaviors and preventing the development of more adaptive or pro-social behaviors.
2. In these instances, the Psychology Service, with the referring treatment team, completes a Functional Assessment of behaviors that require in-depth assessment in order to determine the function of the problematic behaviors and arrive at treatment recommendations. This evaluation includes a functional assessment of *each* problem behavior.
3. When a Functional Assessment has been conducted, a report summarizing the results of the evaluation is completed and submitted to the referring team. The original report is maintained in the patient's medical record, behind the Non-medical Assessments tab.

E. DEVELOPMENT OF BEHAVIORAL INTERVENTIONS

1. Type I Behavioral Interventions:

In many instances, behavioral interventions may be incorporated into the individual's treatment plan directly following the initial consultation meeting.

In these instances, the referring treatment team collaborates with the psychologist on the development and implementation of the interventions. When behavioral interventions are indicated, an instruction sheet for staff implementing the plan will be developed and circulated among appropriate staff. A copy of the instruction sheet will be filed in the Treatment Plan section of the patient's medical record.

2. Type II Behavioral Interventions:

For more complex behavioral issues, (e.g., those which require a formal Functional Assessment), a second consultation with the team is held following completion of the Functional Assessment to review its results and develop behavioral and other discipline-specific interventions to address the behaviors of interest. Written Type II Behavioral Interventions are more detailed and specific plans which are written separately and maintained in the patient's medical record behind the "Treatment Plan" tab. In these instances, Type II interventions are specifically referred to in the patient's treatment plan, in the intervention section under the relevant problems and goal statements.

F. ORIENTATION AND TRAINING FOR BEHAVIORAL INTERVENTIONS

1. The Treatment Team and consulting psychologist shall insure that information relevant to the implementation of behavioral interventions is communicated to relevant staff.
2. The consulting psychologist shall communicate with the Treatment Mall staff to assure that they are also apprised of behavioral interventions to encourage consistency in implementation across settings.
3. Training in the implementation of behavioral interventions shall be provided by the consulting psychologist or other members of the Psychology Service to all staff having frequent contact with the patient (e.g., unit staff, treatment mall staff, canteen staff, etc.)
4. All unit staff required to adhere to behavioral interventions shall receive initial and follow-up training. Training includes review of the written intervention as well as practice implementing behavioral procedures via role-play, and shall include relevant procedures and processes for data collection, when indicated.

G. DATA COLLECTION FOR BEHAVIORAL INTERVENTIONS

1. Data Collection for Type I and Type II Interventions:

a. Team's perceptions of the frequency and severity of problem behaviors are taken prior to the initiation of behavioral interventions, and on a weekly basis thereafter, via the **Quality of Life Factors Assessment Scale (Appendix B).**

b. The psychologist, with input from the team, will complete this scale during regularly scheduled rounds or treatment planning meetings. A second form will be completed with the patient on the same schedule. These forms are maintained in the Progress Notes section of the patient's Medical Record. Information obtained is used to assess treatment effectiveness and to facilitate decisions regarding treatment revision or discontinuation.

2. Additional Data Collection for Type II Interventions:

a. In addition to the data collection procedures outlined above, which provide qualitative assessments of problem severity and team and patient perceptions of frequency, *quantitative* data regarding the frequency of specific target and replacement behaviors (and other indicators of treatment effectiveness, such as frequency of seclusion or restraint) are used to facilitate decisions about treatment revision and/or discontinuation.
b. Baseline data are collected on relevant dimensions of the behavior or symptomatology, preferably *prior* to implementation of a behavioral intervention. In some cases, and in the interest of expeditious provision of treatment, baseline data may be gathered retrospectively from the patient's Medical Record.
c. Unit staff collect data on targeted behaviors as specified in the behavioral intervention plan, using measures appropriate to the behavior, symptom or circumstances being assessed. The psychologist, in coordination with the Nurse Manager assigned to the unit, shall assure that the staff responsible for data collection are trained to competency. Data are summarized by the psychologist on a weekly basis in the Progress Notes section of the patient's medical record.

H. OVERSIGHT OF TREATMENT EFFECTIVENESS

1. The psychologist updates the treatment team on the patient's progress during team rounds and reviews each behavioral intervention and any relevant data with the treatment team during the bi-weekly (or monthly) Treatment Plan Review (or more often if necessary). At this meeting, the treatment team decides whether to continue current procedures; make procedural adjustment or programmatic revisions; conduct additional staff training; seek additional consultation; or make changes in medical or other disciplinary regimens (in concert with appropriate disciplines.)
2. **For Type I and Type II Interventions**, monitoring of clinical effectiveness of interventions is assessed bi-weekly via the Quality of Life Factors Assessment Scale (completed weekly by both the team and patient).
3. **For Type II Interventions**, monthly reviews are documented by the psychologist in the progress notes section of the patient's medical record.

I. OVERSIGHT OF TREATMENT IMPLEMENTATION

1. Treatment Integrity Checks are conducted by a member of the Psychology Service in conjunction with the Nurse Manager on an as-needed basis, when concerns arise as to the efficacy of a behavioral intervention or the consistent or proper implementation of the intervention by treatment team staff. Re-training shall be conducted as needed when treatment integrity is determined to be a problem.

IV. REFERENCES:

V. ATTACHMENTS:

A. Behavioral Consultation Feedback Form
B. Quality of Life Factors Assessment Scale